STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

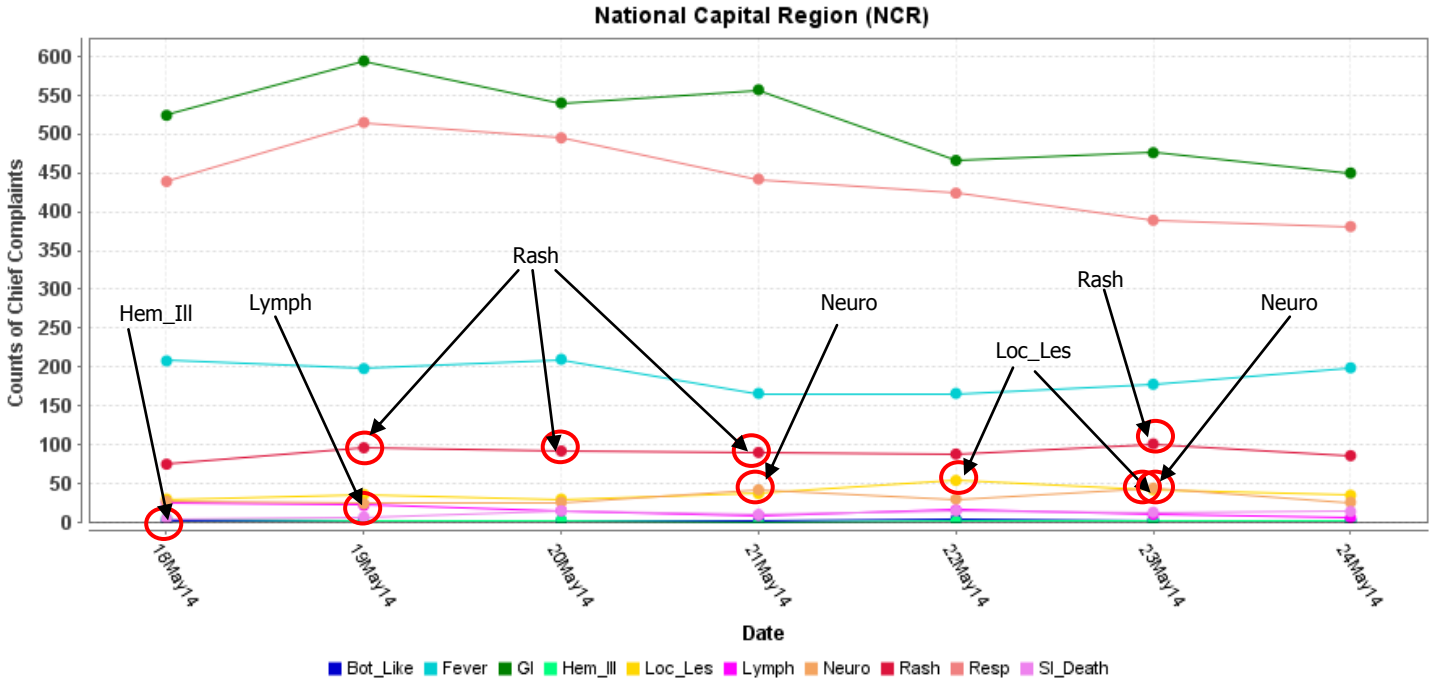
May 30, 2014

Public Health & Emergency Preparedness Bulletin: # 2014:21
Reporting for the week ending 05/24/14 (MMWR Week #21)

CURRENT HOMELAND SECURITY THREAT LEVELS

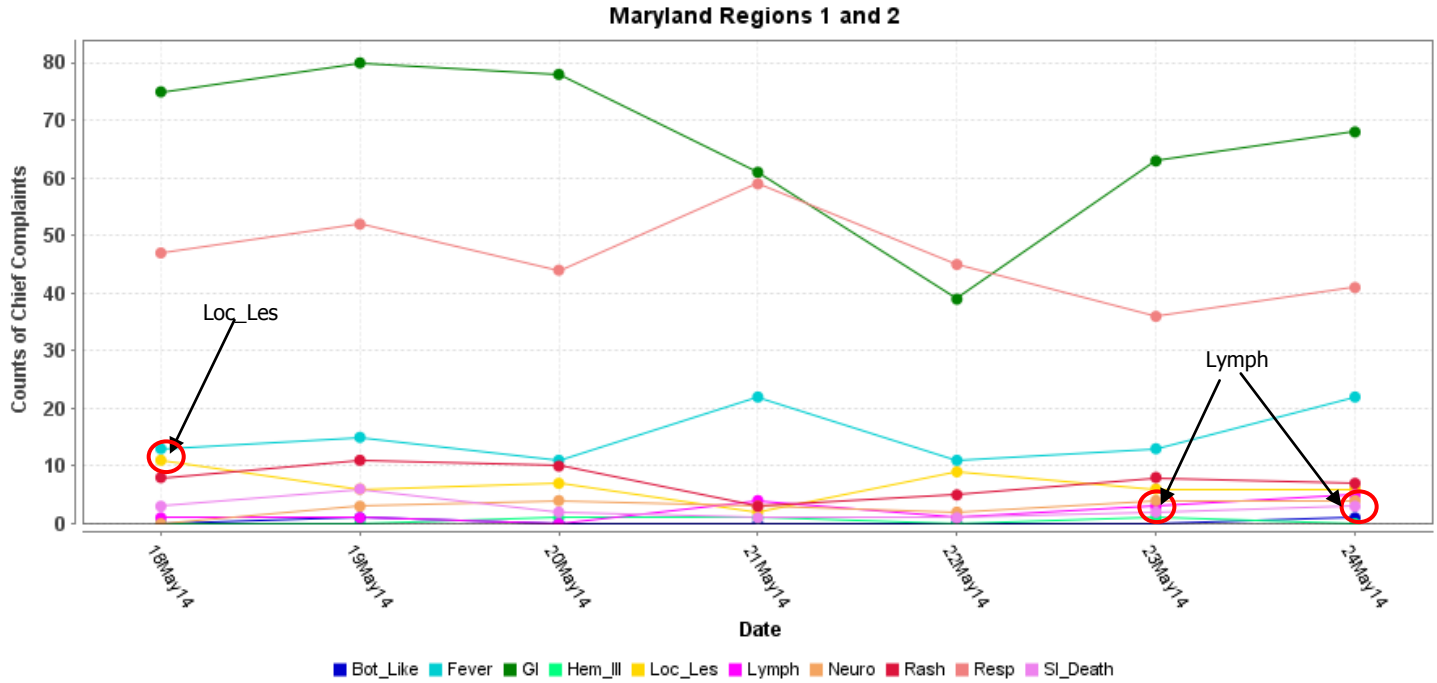
National: **No Active Alerts**
Maryland: **Level Four (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

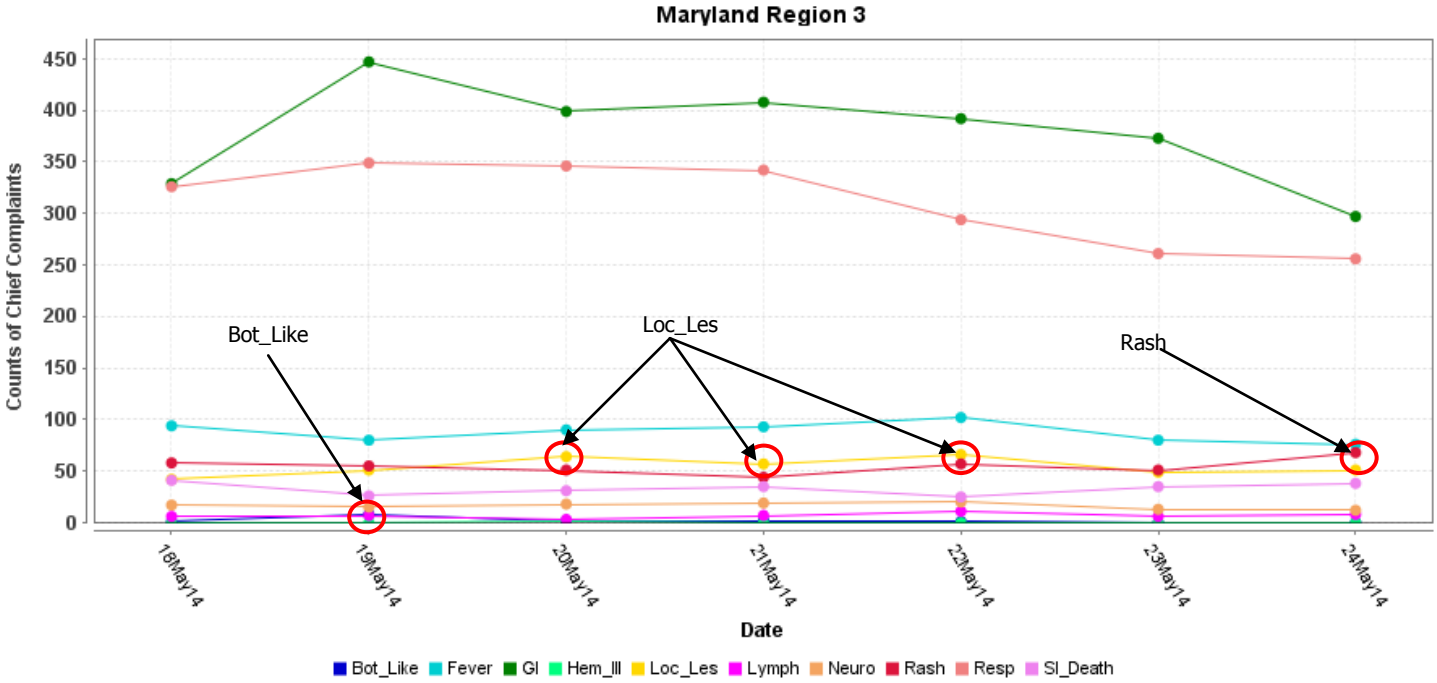


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

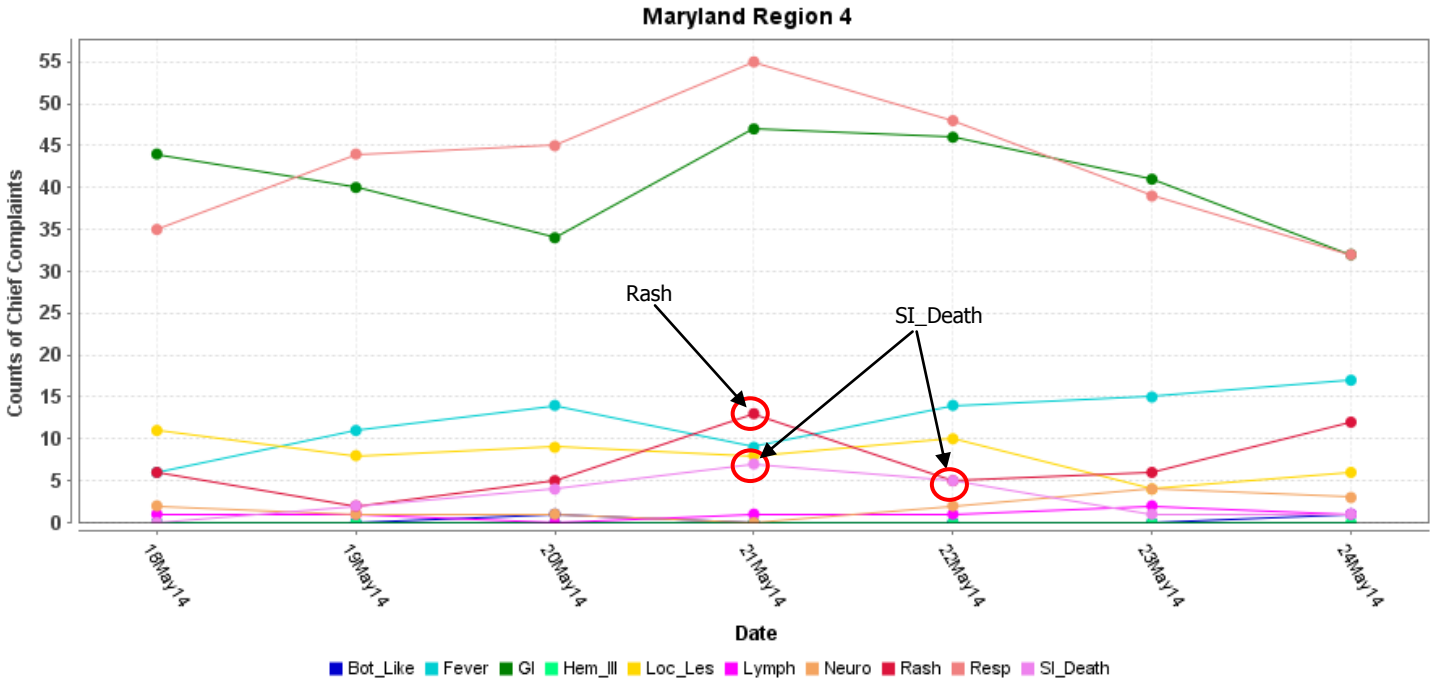
MARYLAND ESSENCE:



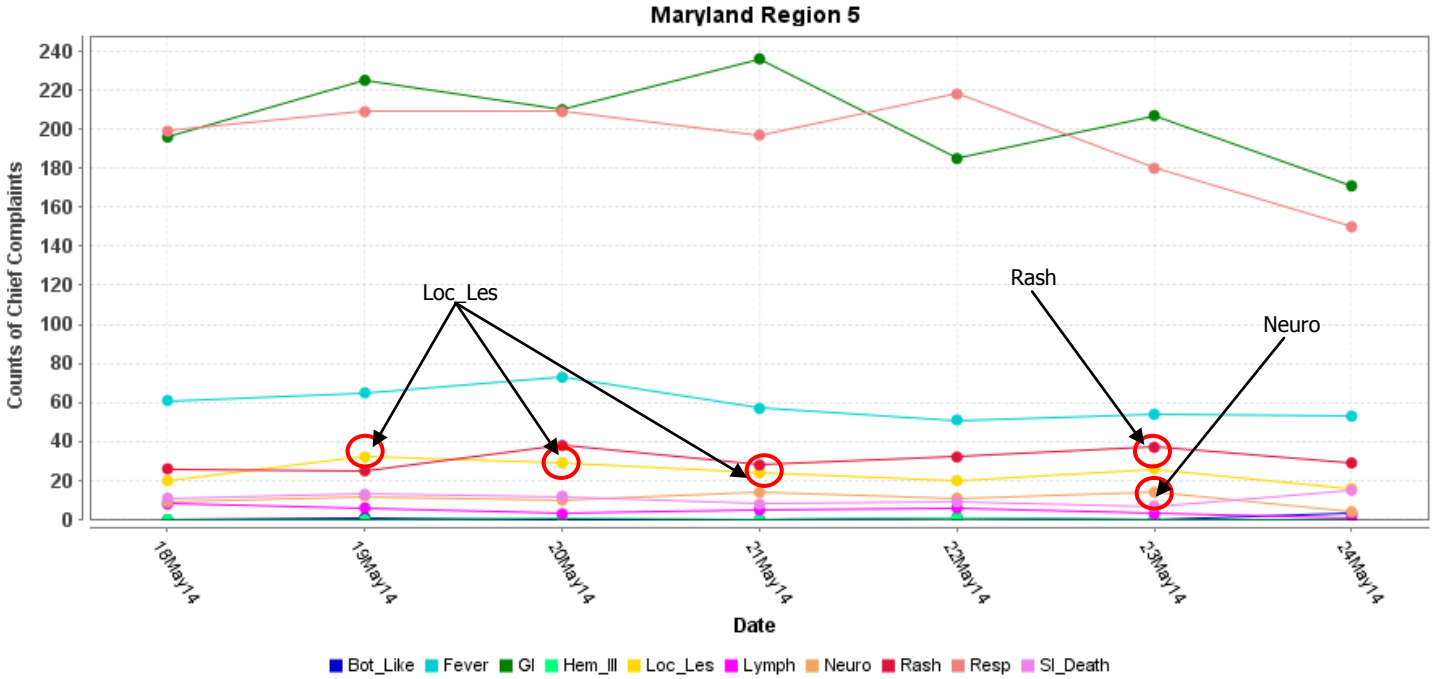
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



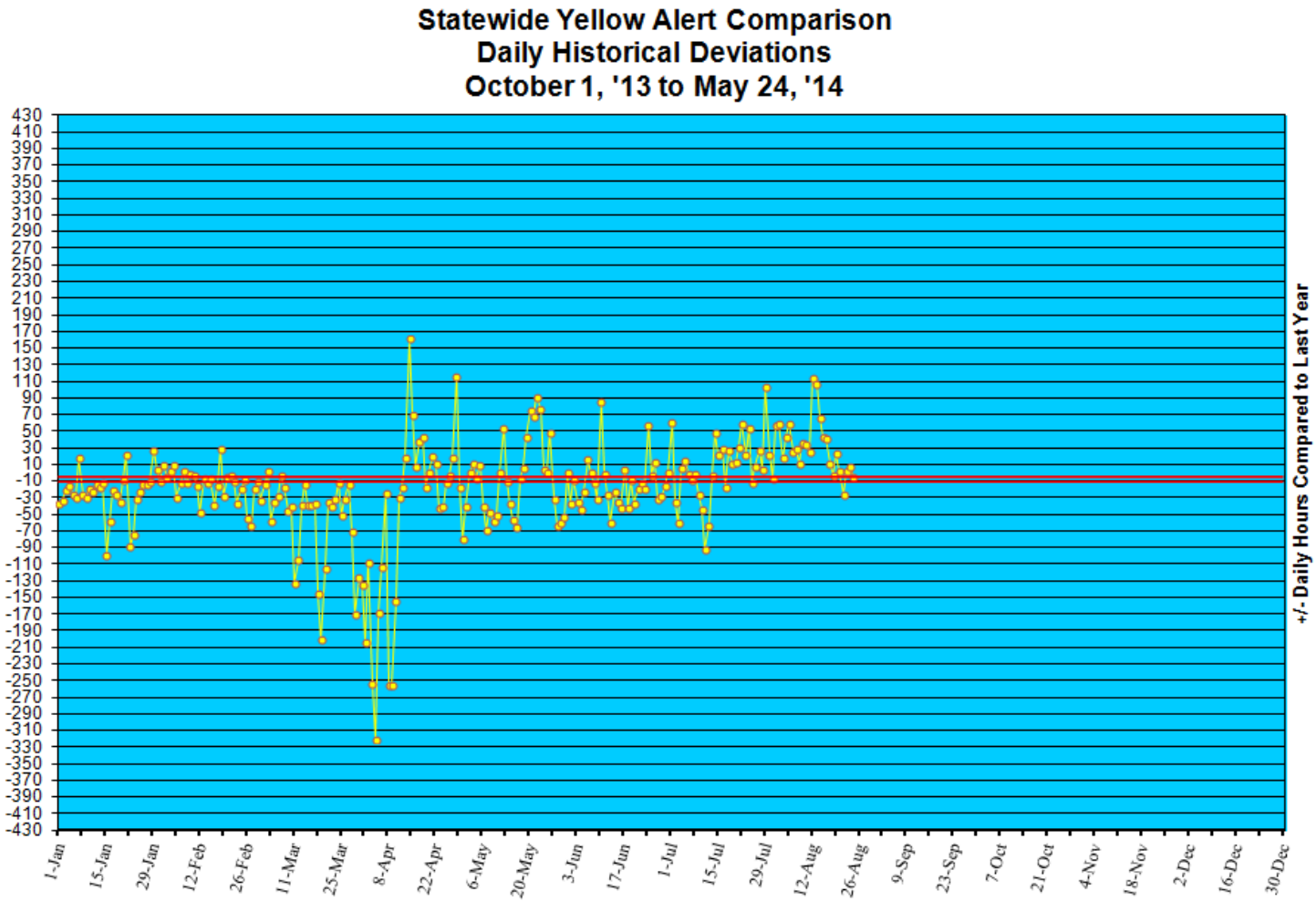
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/13.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in April 2014 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (May 18 - May 24, 2014):	8	0
Prior week (May 11 - May 17, 2014):	4	0
Week#21, 2013 (May 19 - May 25, 2014):	8	0

2 outbreaks were reported to DHMH during MMWR Week 21 (May 18 - May 24, 2014)

1 Gastroenteritis Outbreaks
1 outbreak of GASTROENTERITIS in a Residential Treatment Facility

1 Respiratory Illness Outbreaks
1 outbreak of ILI/PNEUMONIA in an Assisted Living Facility

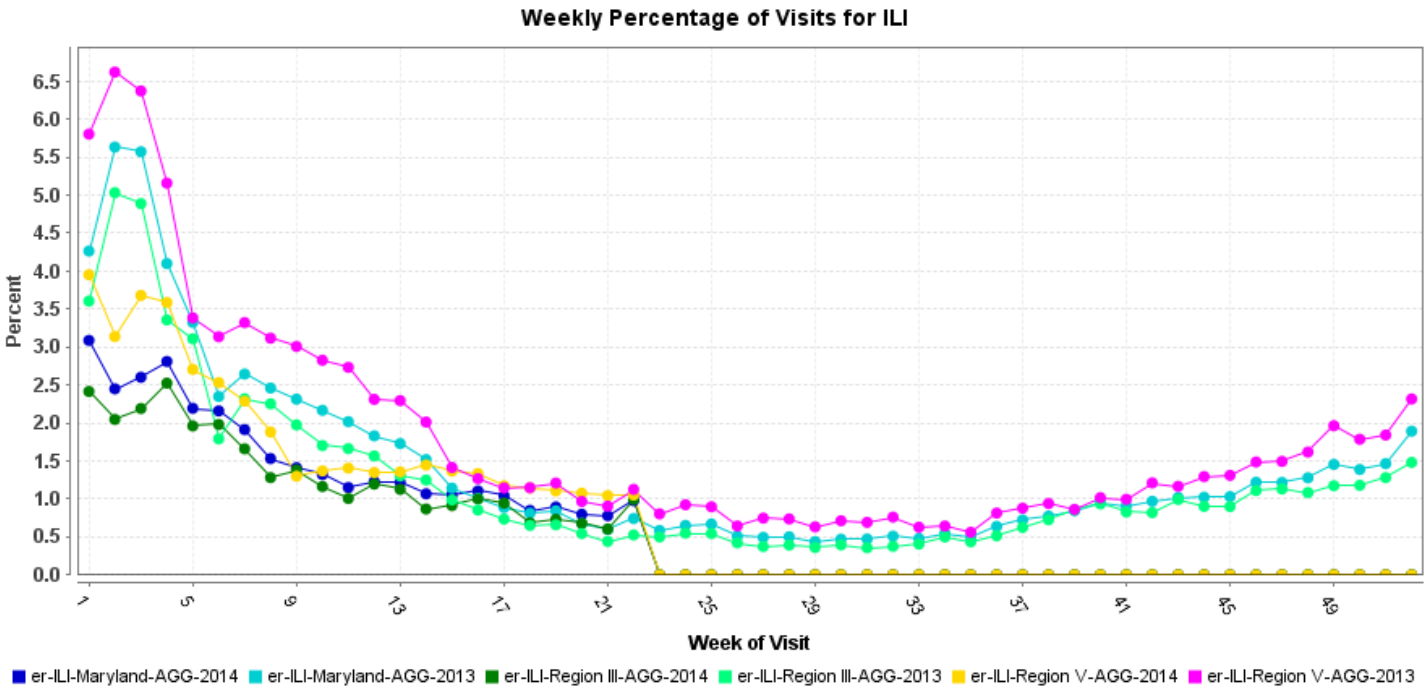
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting generally occurs October through May. The final reporting period for 2014 was MMWR Week 20.

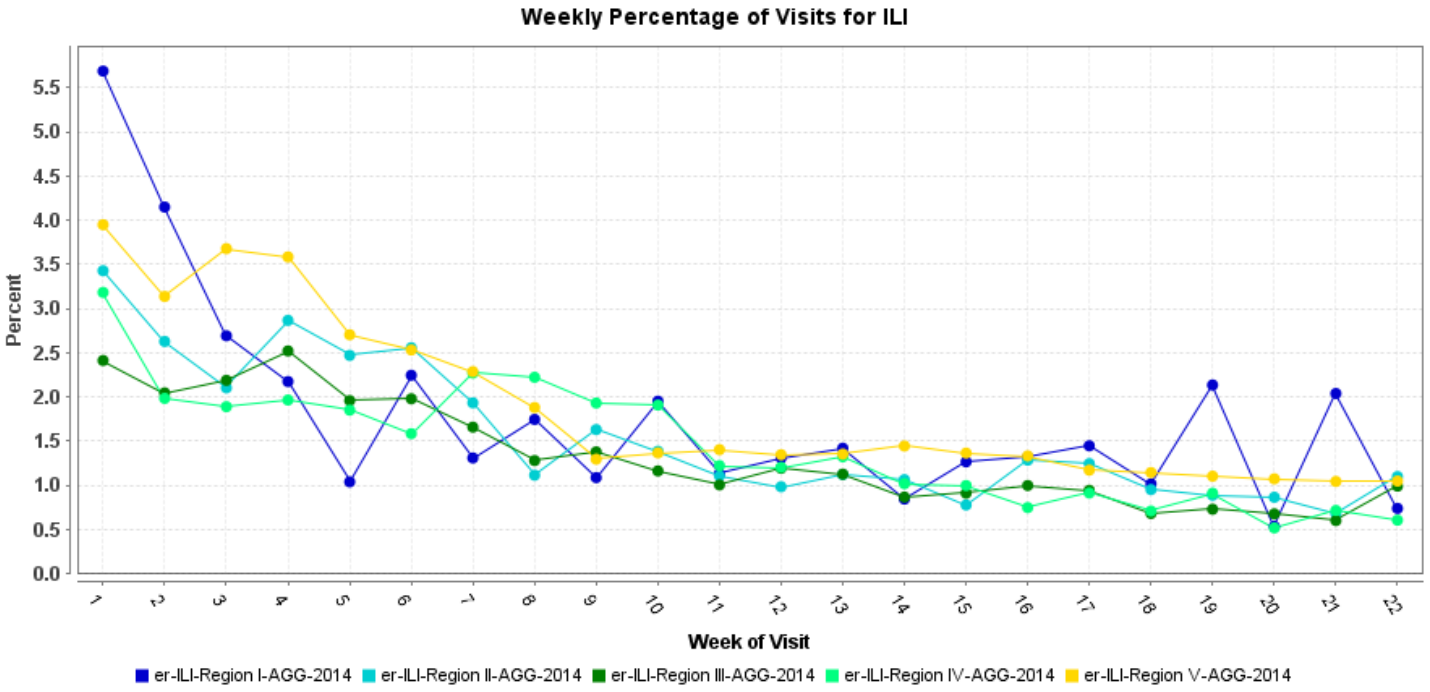
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



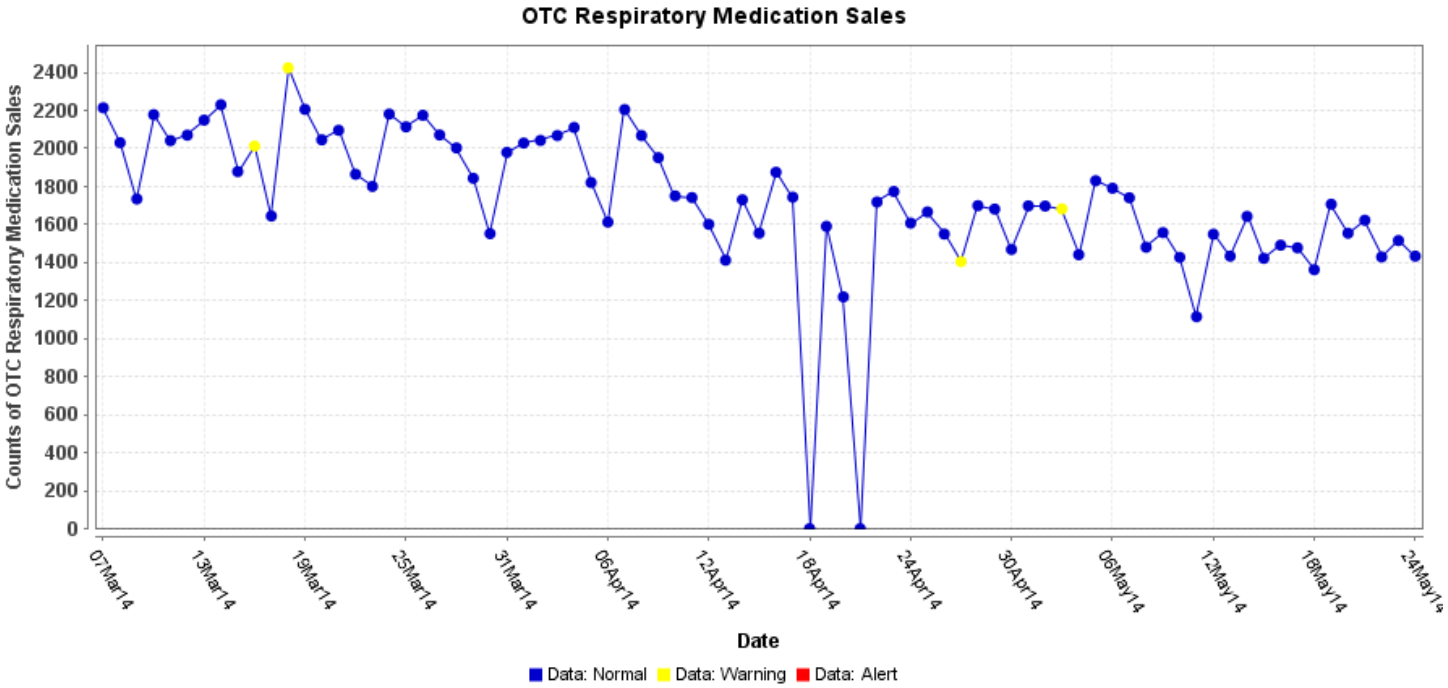
* Includes 2013 and 2014 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2014 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of January 24, 2014, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 650, of which 386 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

NATIONAL DISEASE REPORTS*

HANTAVIRUS (COLORADO): 24 May 2014, Public health officials said on Thursday [22 May 2014] that a San Luis Valley [Colorado] resident had been hospitalized after developing hantavirus pulmonary syndrome after exposure to [a] hantavirus. Earlier this month [May 2014], a Saguache County [Colorado] resident died after being exposed to the virus in Rio Grande County [Colorado]. The commonest form of exposure to the virus comes from breathing dust containing deer rodent droppings or urine that's easily stirred up during spring cleaning. (Emerging Infectious Diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (KANSAS): 24 May 2014, At least 4 people in the Wichita [Kansas] area have been diagnosed with Escherichia coli [infection] after a private event, according to Kansas Department of Health and Environment spokeswoman Aimee Rosenow; 2 of the patients are from Sedgwick County and 2 are from Harvey County. One of the Harvey County patients is also being treated for hemolytic uremic syndrome (HUS), a type of kidney failure that is a complication of E. coli. It's unclear whether more people attended the event. Infection can occur from coming into contact with contaminated food, water, animals or people, according to the Centers for Disease Control and Prevention. There are 3 other cases being investigated in the state, Rosenow said on Friday [23 May 2014], but they do not appear to be related to the other cases; 2 of those patients are from Cowley County and 1 from Nemaha County. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

HANTAVIRUS (OKLAHOMA): 24 May 2014, The Oklahoma State Department of Health (OSDH) announced today [22 May 2014] that a Texas County adult has died due to hantavirus pulmonary syndrome (HPS). This is the 1st case confirmed in Oklahoma during 2014, and the 5th Oklahoma case since hantavirus [infections] were 1st recognized in the United States in 1993. During 2013, 2 cases of HPS occurred in Oklahoma; both individuals died as a result of this disease. All Oklahoma cases have been from northwestern Oklahoma. Investigations of each HPS case revealed exposure likely occurred when dust was stirred up in rodent-infested areas while cleaning. Hantavirus [infection] is a life-threatening disease spread to humans by rodents that has symptoms similar to influenza. Hantavirus[es] are carried by rodents, especially deer mice [Peromyscus maniculatus in North America]. The virus is found in their urine and feces, but it does not make the animal sick. It is believed that humans can get sick with this virus if they come in contact with [virus] contaminated dust from mice nests or droppings. You may come in contact with the dust when cleaning homes, sheds, or other enclosed areas that have been empty for a long time. Hantavirus[es] do not spread between humans [in North America]. The Centers for Disease Control and Prevention (CDC) divides the symptoms of hantavirus between "early" and "late" symptoms. Early symptoms include fatigue, fever and muscle aches, especially in the large muscle groups -- thighs, hips, back, and sometimes shoulders. These symptoms are universal. There may also be headaches, dizziness, chills, and abdominal problems, such as nausea, vomiting, diarrhea, and abdominal pain. About half of all HPS patients experience these symptoms. Late symptoms of HPS occur 4-10 days after the initial phase of illness. These include coughing and shortness of breath, with the sensation of, as one survivor put it, a "tight band around my chest and a pillow over my face" as the lungs fill with fluid. HPS has a mortality rate of 38 per cent, according to the agency. The OSDH urges residents to be mindful of the presence or evidence of wild rodents when conducting clean-up activities in a house, barn or other out buildings, especially in rural areas. Infected rodents do not show signs of illness but shed the virus in their urine, feces, and saliva. The OSDH recommends the following steps to safely clean up areas with possible rodent infestations or waste:
- ventilate areas inside of closed buildings for at least 30 minutes before you clean by opening doors and windows;
- use rubber gloves and spray the rodent nest, dead rodents, or droppings until soaked with a household disinfectant solution of 1.5 cups of bleach in 1 gallon of water;
- remove the nest or rodent(s) using a long-handled shovel or rubber gloves;
- double-bag the nest and dispose in trash. Persons in rural areas may bury the waste 2 to 3 feet deep;
- spray the area again with the disinfectant solution;
- wear rubber gloves and wipe up the area with paper towels or rags and double-bag and dispose them in trash container;
- wash your hands with soap and water immediately after the cleanup.
(Emerging Infectious Diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (WASHINGTON, IDAHO): Health officials in Washington and Idaho say people should avoid eating raw clover sprouts from an Idaho producer after the sprouts were linked to 7 confirmed and 3 probable cases of Escherichia coli illness in the north west. The cases include 5 people in Spokane County (Washington), 3 in Kootenai County (Idaho), and 2 in King County (Washington). All took ill in the past 2 weeks and 5 were hospitalized. 9 of the 10 individuals reported eating sprouts in sandwiches served at restaurants about 5 days before they were sick. The initial investigation indicates a strong link to spouts supplied by Evergreen Fresh Sprouts of Moyie Springs, Idaho, near Bonners Ferry, the Washington and Idaho state health departments said. "We advise people not to eat raw clover sprouts from Evergreen Fresh Sprouts until further notice," said Dr. Kathy Lofy, Washington's state health officer. "If you have these products at home, you should throw them out." Panhandle Health District recommended people avoid eating raw clover sprouts, but the public health agency for North Idaho chose not to name the producer or any of the restaurants where the patients ate sprouts.

"What we have is a lot of circumstantial evidence that certainly says something. But we don't have final test results yet," said Cynthia Taggart, Panhandle's public information officer. "We just want people to know that all the people had the raw clover sprouts and they all got E. coli." David Scharf, owner of Evergreen Fresh Sprouts, said state health officials jumped the gun pointing the finger at his business. "I find that it is very ambiguous to say that my product is bad," Scharf told The Spokesman-Review. He said he tests his sprouts before they leave the warehouse and also tests the spent water, according to federal rules. "I have documentation stating my sprouts are good." Evergreen was singled out in similar investigation in 2011 when the FDA demanded it voluntarily recall products as a salmonella outbreak unfolded, sickening 25 people in 5 states. Test results showed no bacteria were found in the Evergreen produce at that time, but the FDA stuck by its conclusion that the business was the origin of the outbreak. The clover sprouts suspected in the current E. coli O121 outbreak were eaten in sandwiches at Jimmy John's Gourmet Sandwiches in King and Spokane counties, 2 Pita Pit locations in Spokane County, and Daanen's Deli and a Jimmy John's in Kootenai County, Washington state health officials said. The restaurants voluntarily suspended serving sprouts, officials said. Raw clover sprouts also are sold in delis, supermarkets, and specialty food stores. Public health officials advised people who have raw clover sprouts at home to throw them out. "Until the investigation is complete, we recommend that people avoid consuming raw clover sprouts," said Mary Petty, Panhandle Health District's epidemiology program manager. Public health officials in the region are working with the FDA and the Centers for Disease Control and Prevention to investigate the cause of the illness. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

CRIMEAN-CONGO HEMORRHAGIC FEVER (ENGLAND): 24 May 2014, At the Pakistan Institute of Medical Sciences (Pims), 3 patients believed to have Crimean-Congo hemorrhagic fever (CCHF) -- one later confirmed -- died at Pims in April and May this year [2014], Pims spokesperson Dr. Ayesha Eshani said. A senior physician sharing details about the most recent CCHF patient, said a man, an Afghan national, tested positive for CCHF and died late on Wednesday [21 May 2014]. According to his travel history, he came to Peshawar [Khyber-Pakhtunkhwa Province] from Afghanistan and then traveled to Islamabad, where he fell ill and was admitted to Pims. The physician added that 2 other patients were suspected of having the disease. The Pims administration has started monitoring their staff to ensure that none of them has been affected by the viral disease. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

EBOLA VIRUS DISEASE (GUINEA): 24 May 2014, Guinean health officials announced 2 new confirmed cases of Ebola virus disease on Friday [23 May 2014] in an area previously untouched by the virus, which has killed more than 100 people in West Africa, but which Guinea's government has said is now under control. West Africa's 1st deadly outbreak of Ebola virus disease spread from a remote corner of the country to the capital, Conakry, and into neighboring Liberia, causing panic across a region struggling with weak healthcare systems and porous borders. "We recorded 2 new cases in Telimele [Telimele Prefecture]. They are the 1st in this locality, which is in fact a new outbreak," said Mamadou Rafi Diallo, a spokesperson for Guinea's Health Ministry, adding that the 2 were being treated in isolation. Ebola virus disease, a hemorrhagic fever, has a fatality rate of up to 90 per cent and causes symptoms ranging from flu-like pains to internal and external bleeding. It is transmitted between humans by touching victims or through bodily fluids. The new cases may have been due to the 2 coming into contact with the body of another victim at a funeral service. Such contact has been responsible for a number of transmissions since the outbreak was 1st identified in March [2014]. "We're talking about a woman who was buried there without care," Diallo said. The authorities were not considering the dead woman as a confirmed case as she had not been tested for the disease. The government said it was also closely monitoring 41 people who had come into contact with the 2 confirmed sufferers in Telimele, which is about 250 km (160 miles) from the capital Conakry. "The government is working with partners to put in place a treatment center, to identify everyone who has made contact with [these?] Ebola victims as well as raise awareness and distribute hygiene kits," the government said in a statement on Friday [23 May 2014]. Ebola has infected around 170 people elsewhere in Guinea and in Liberia and killed more than 100, although the death toll is likely higher as the government is only counting cases that have been confirmed through laboratory testing. No new cases of Ebola have been detected since [26 Apr 2014] in Conakry, where an outbreak could pose the biggest threat of an epidemic due to the city's role as an international travel hub. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

LASSA FEVER (NIGERIA): 22 May 2014, The Ebonyi commissioner for health, Sunday Nwangele, said on Tue 20 May 2014 that 6 medical staff of the Federal Teaching Hospital, FETHA, Abakaliki, had tested positive for Lassa fever. Mr. Nwangele confirmed to journalists in Abakaliki that the 6 were among the 11 doctors and 5 nurses who were rushed to the virology laboratory in Irrua, Edo for testing. The state chapter of the Nigerian Medical Association, NMA, last Thursday [15 May 2014] announced that 11 doctors and 5 nurses had contracted the disease after participating in a clinical operation on a pregnant woman in the hospital. The state NMA chairman, Chidi Esike, told journalists at a news conference in Abakaliki that the woman and her baby died a few days after they were discharged from the hospital. Mr. Esike also said that the state had recorded 25 deaths due to Lassa fever since 2005, adding that many of them were medical personnel. Commenting on the development, the commissioner said: "No life was lost except for the pregnant woman and her baby through whom the health workers contracted the disease. The 16 patients were rushed to Irrua when they were discovered to be resistant to malaria fever treatment, and 6 of them have been confirmed positive through a laboratory test. They are now undergoing intensive care treatment, and they are all stable. But I want to say that not every case of resistance to malaria fever treatment is a Lassa fever case, he said. Mr. Nwangele said that the joint committee set up by the state Ministry of Health and FETHA on Lassa fever had evolved a 2-way approach for treatment of the disease. According to him, the method involves short and long-term control measures. "On the short-term approach, the suspected patient is administered with prophylaxis tablets, while on the long-term control, the patient that is clinically down receives injectable drugs. The state government is partnering with FETHA on the short-term control method, while government has in this regard donated tablets and personal protection equipment to affected patients. The state would not accept being an endemic state and has mapped out land for the construction of a virology laboratory in Abakaliki," he said. Mr. Nwangele noted that most of the Lassa fever cases in the area were imported, and manifested in the form of "operateable cases." He said that the pregnant woman through whom the health workers contracted the disease was not from the state. "We were contacted by the dermatology team to determine her close contacts and how she got the disease. I want to advise the public to always keep their environment clean, avoid exposing edibles to rats, and if possible exterminate all rats around them," he advised. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

CHOLERA (SOUTH SUDAN): 22 May 2014, The United Nations says 13 people have died so far in an outbreak of cholera in South Sudan. The 1st case of cholera was reported in the capital, Juba, on 15 May 2014. As of Tue 20 May 2014, the number of cases was 266. The spokesman for the UN secretary-general told reporters on Wed 21 May 2014 that humanitarian workers are trying to improve sanitation inside UN bases where thousands of civilians have taken refuge since violence erupted in December 2013. Stephane Dujarric says easing the "overcrowded" bases in cities such as Bentiu and Malakal remains a top UN priority. Efforts to fight the cholera outbreak also include vaccinating 13 000 people so far in Bentiu. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (SCOTLAND): 21 May 2014, An outbreak of Escherichia coli O157 [infection] in Fife is still being investigated by NHS [National Health Service] Fife's Public Health Department. There is a cluster of 5 confirmed cases, and 6 suspected cases, associated with Khushi's Indian Restaurant in Dunfermline. NHS Fife said none of the cases are in hospital, and all are recovering at home. Khushi's is co-operating fully with Fife Council's environmental health department and has re-opened following deep-cleaning and other measures that were required to be put in place. The initial outbreak was revealed by NHS Fife on Friday, 16 May 2014. The incubation period for E. coli O157 can be as long as 14 days. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

UNDIAGNOSED FOOD POISONING (MADAGASCAR): 18 May 2014, The death toll is mounting in the rural town of Belobaka in the district of Mahajanga II, after people consumed a dish made with sea turtle meat, which was poisonous. "Eight children died after mass food poisoning. Four were killed in the fokontany Antsahanitia; one died on the road [on the way to the hospital], and 3 others died in the Androva University Hospital," recounted journalist Luc Fabien Raoeliariseheno in the Boeny region yesterday [13 May 2014]. These deaths were mainly due to delays in obtaining care, causing advanced dehydration in the children. Breastfeeding also resulted in the transfer of the toxin between the mother and an already ill child. 50 people have been admitted to the health centers following consumption of the toxic sea turtle meat. Cases are also likely to increase, as the inhabitants of Betsako, commonly known as Belobaka, have also bought sea turtle meat. Some local sources also claimed that meat from the sea turtle has been seen in the village of Mahavoky Avaratra. The search for turtle meat was well launched in the markets by Monday [12 May 2014] in the district of Mahajanga I and II. There is a general lack of awareness of poor people to the danger. The same situation has already occurred in Toliara and Antalaha, according Christmas Rakotonirina Etienne, Regional Director of Fisheries in the region Boeny. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/ or follow us on Facebook at www.facebook.com/MarylandOPR.

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

Zachary Faigen, MSPH, REHS
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-6745
Fax: 410-333-5000
Email: Zachary.Faigen@maryland.gov

Anikah H. Salim, MPH, CPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-2074
Fax: 410-333-5000
Email: Anikah.Salim@maryland.gov

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumococcal meningitis, viral encephalitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephalitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable